SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*46054*
Company Tracking Number:	*AR-11-2010*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*2010 Individual Medicare Supplement Plans*		
Project Name/Number:	*2010 MAPA Screens/AR-11-2010*		

Filing at a Glance

Company: Humana Insurance Company

Product Name: 2010 Individual Medicare Supplement Plans	SERFF Tr Num: HUMA-126693791	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 46054
Sub-TOI: MS08I.001 Plan A 2010	Co Tr Num: AR-11-2010	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Michele Zabel, Dennis Cowart, Paula Williamson, Adrianna Maki, Mary Walker	Disposition Date: 07/08/2010
	Date Submitted: 06/25/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2010 MAPA Screens	Status of Filing in Domicile:
Project Number: AR-11-2010	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/08/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/08/2010
Deemer Date:	Created By: Adrianna Maki
Submitted By: Adrianna Maki	Corresponding Filing Tracking Number: AR-11-2010

Filing Description:

RE: Humana Insurance Company/NAIC # 119, 73288
Medicare Supplement Electronic Enrollment - MAPA Screens

Please find enclosed for your review and approval screens necessary to complete an application for Humana’s

SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
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Medicare Supplement insurance plans electronically by a Humana licensed agent. This program is designed for use on the agent's computer during a sales appointment. All other required material to complete the sale is available and provided in hard copy format. All hard copy materials have been previously filed and approved by your office.

1. GN85026M10MAPA - Application Screens
2. GN97031M10MAPA - Notice of Replacement Form Screens

Policy forms issued by Humana Insurance Company: ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, and ARMESM10L.

If you have any questions or require additional information, I can be reached in addition to SERFF at (502) 476-1262 or by email at amaki@humana.com.

Company and Contact

Filing Contact Information

Adrianna Maki, Compliance Analyst	amaki@humana.com
500 West Main Street	502-476-1262 [Phone]
Louisville, KY 40202	

Filing Company Information

Humana Insurance Company	CoCode: 73288	State of Domicile: Wisconsin
1100 Employers Boulevard	Group Code: 119	Company Type: Life & Health
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-1263473	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50 per form X 2 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	$100.00	06/25/2010	37539364

SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	07/08/2010	07/08/2010

SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
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Disposition

Disposition Date: 07/08/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*46054*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	MAPA Application Screens	Approved	Yes
Form	MAPA Notice of Replacement Screens	Approved	Yes

SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*46054*
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Product Name:	*2010 Individual Medicare Supplement Plans*		
Project Name/Number:	*2010 MAPA Screens/AR-11-2010*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/08/2010	GN85026M10MAPA	Application/ Enrollment Form	MAPA Application Screens	Initial		0.000	GN85026M10 MAPA.pdf
Approved 07/08/2010	GN97031M10MAPA	Other	MAPA Notice of Replacement Screens	Initial		0.000	GN97031M10 MAPA.pdf

Review

Return to Application | Next

Client Information

Proposed Effective Date

Last Name | MI

First Name | Social Security Number (Optional) | Re-enter SSN

Permanent Address

Address1

Address 2/Apt# | City

State | Zip | County

Mailing Address (If different from Permanent Address)

Address1

Address 2/Apt# | City

State | Zip

Email Address (Optional)

E-mail address, if available, will be used as a means to communicate only Humana information.

Preferred Method of Communication:

Telephone | Email | Mail

Person to notify in case of emergency (nearest relative or friend)

Last Name | First Name

Relationship to Applicant | Phone

Medical Health Insurance

Last Name

Gender
Male Female

First Name MI

D.O.B

Please complete the information below as it appears on your Medicare card

Medicare Claim Number

Re-enter Medicare Claim Number

Hospital Insurance (Part A)

Phone
( ) -

Medical Insurance (Part B)

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

Are you applying for coverage during your Medicare Supplement Open Enrollment Period? Yes No

Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? Yes No

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance.

Did you have Medicare Coverage prior to age 65? Yes No

Have you used tobacco products within the last 12 months? Yes No

If your application is accepted, and you answered NO to both questions, you qualify for the Preferred rates.

***You do not need more than one Medicare Supplement policy.**

***You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.**

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

***If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.**

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. A copy of the notice from your prior insurer may be requested.

Did you turn age 65 in the last six months? ○ Yes ○ No

Did you enroll in Medicare Part B in the last six months? ○ Yes ○ No

If yes, what is the effective date?

Are you covered for medical assistance through the State Medicaid program? ○ Yes ○ No

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

If yes, will Medicaid pay your premiums for this Medicare Supplement policy? ○ Yes ○ No

Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium? ○ Yes ○ No

If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. ○ Yes ○ No

START **/01/**

END / /

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ○ Yes ○ No

Was this your first time in this type of Medicare plan? ○ Yes ○ No

Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ○ Yes ○ No

Do you have another Medicare supplement policy in force? ○ Yes ○ No

If so, with what company?

What plan do you have? Please identify the plan type that corresponds to your current Medicare Supplement, or possibly Medicare Select, plan. --Select a Plan --

If so, do you intend to replace your current Medicare Supplement policy with this policy? ○ Yes ○ No

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) ○ Yes ○ No

If so, with what company?

What policy do you have?

What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)

START **/01/**

END / /

Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? ○ Yes ○ No

Yes or No answers are required to the following questions, unless you indicated that you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance. PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair?	○ Yes ○ No
In the past 90 days have you received Home Health care?	○ Yes ○ No
Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:	
Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders?	○ Yes ○ No
Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year?	○ Yes ○ No
Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig's Disease?	○ Yes ○ No
Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia, other major depressive disorders, mental or nervous disorders, cirrhosis, alcoholism or drug abuse?	○ Yes ○ No
Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection?	○ Yes ○ No
Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily?	○ Yes ○ No
Internal cancer, leukemia or melanoma?	○ Yes ○ No
Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions?	○ Yes ○ No
Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries?	○ Yes ○ No
Organ transplantation?	○ Yes ○ No

Monthly Premium

Monthly Premium $

In order for us to process your application you must submit your first month's premium.

Initial Payment

Enter Initial Payment only if you are submitting more than your first month's premium.

Initial Payment $

Please select how you would like to be billed for your initial payment. Humana will only process your payment after your policy has been issued.

- Visa 
- MasterCard 
- Discover 
- Automatic Withdrawal

I hereby authorize Humana to initiate debit/credit entries to my Checking/Saving account and/or credit card, as indicated below, in amounts appropriate to my coverage; and authorize the bank named below to debit/credit same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given reasonable written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

Card Number

Expiration Date

Future Payment Options

You can pay your premium monthly by automatic bank withdrawal, credit card charge or coupon book. Choosing automatic bank withdrawal or credit card charge provides a $2 discount on your monthly premium. Generally, automatic bank withdrawals and credit card charges are made the first week of each month.

- Visa 
- MasterCard 
- Discover 
- Automatic Withdrawal
- Coupon Book

I hereby authorize Humana to initiate debit/credit entries to my Checking/Saving account and/or credit card, as indicated below, in amounts appropriate to my coverage; and authorize the bank named below to debit/credit same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given reasonable written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

Card Number

Expiration Date

Office Use Only

Plan Representative | REP # | Affinity Partner | GR

Date | Agency | Agency ID | Affinity Partner Location | BN

Agent Code | MGA Code | Referring Broker Name | Referring Broker SAN | Affinity TID

Campaign

All health insurance policies sold to the applicant which are still in force (if none, write NONE):

Company | Type

All health insurance policies sold to the applicant with in the past five years which are no longer in force (if none, write NONE)

Company | Type

Source | Sub Source | House Member

Type | Sub Type

Disposition1 | Disposition2 | Disposition3

Products Discussed (Please select all that apply)

- [ ] All
- [ ] PDP
- [ ] MA/MAPD
- [ ] MedSupp
- [ ] Other

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an open enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

Humana Insurance Company[2432 Fortune Drive Lexington, KY 40509]

Return to Application

Next

Online Service Agreement

Agreement with Humana

This agreement is between you, Humana Insurance Company, and its affiliates.

Consent to Electronic Transactions

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.

2. This consent to conduct an electronic transaction only applies to enrollment services.

3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.

4. That I may request a paper copy of this recorded transaction.

5. To be bound by this agreement as stated by law throughout the term of this Agreement.

6. This agreement may be modified at any time if Humana provides notice.

For More Information

Humana, 500 W. Main Street, Louisville, KY 40202

☐ By checking this box, you acknowledge you have read and understand the above information.

Agree

Disagree

GN85026M10MAPA

Signature

You have completed and reviewed the following applications and/or forms:

Humana Medicare Supplement Plan F	Reviewed and Acknowledged
Notice of Replacement Form	Reviewed and Acknowledged
Total Monthly Medicare Supplement Premium	$$$$

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.

Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)

Client Sign

Signature Date

__/__/____

Capture Signature

Agent Sign

Signature Date

__/__/____

Clear Signature

Signature of Witness/Translator or Person assisting in completion of form (other than agent)

Witness/Translator Sign

Signature Date

__/__/____

Witness/Translator Last Name:

Witness/Translator First Name:

Relation:

If you are the authorized legal representative (POA), you must sign above and provide the following information.

Last Name:

MI:

First Name:

Address1:

Address 2/Apt#

City:

State:

Zip:

Phone:

( ) -

Relation to Applicant:

Notice of Replacement

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by Humana Insurance Company. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy/certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan.

The replacement policy/certificate is being purchased for the following reason (check one):

- ○ additional benefits
- ○ fewer benefits and lower premiums
- ○ disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)
- ○ other (please specify)
- ○ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ○ no change in benefits, but lower premiums

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

☐ **By checking this box, you acknowledge you have read and understand the above information.**

Return to Application

Sign

GN97031M10MAPA

SERFF Tracking Number:	*HUMA-126693791*	*State:*	*Arkansas*
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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Accepted for Informational Purposes	07/08/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:			

Please see the Application attached under the Form Schedule tab.

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	N/A		
Comments:			